

REGIONAL CARDIOLOGY ASSOCIATES, P.L.C.

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5625 Water Tower Place, Suite 270 • Clarkston, MI 48346 • Phone: (248) 620-4270 • Fax: (248) 620-4272

PATIENT INFORMATION

Date _____

Name (Last) _____ (First) _____ (MI) _____

Date of birth _____ Age _____ Sex _____ F _____ M _____ Marital Status ___S___M___D___W

Address (Street) _____ Apt./Lot # _____

City, State _____ Zip Code _____

Phone # _____ Social Security _____ Driver's License _____

Work # _____ Employer (Name, Address) _____

Referring Physician _____

Emergency Contact: (Name, Relationship & Phone) _____

PRIMARY INSURANCE INFORMATION

Insurance Co.: _____ Contract # _____ Group # _____

Plan # _____ Insurance Address _____

Insured's Name _____ Relationship _____ Self Spouse Dependent

Insured's Address _____ City, State _____ Zip Code _____

Insured's Employer _____ Insured's Social Security # _____

Date of Birth _____ Sex _____ M _____ F

If the patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance to process your claim more quickly. Thank you!

SECONDARY INSURANCE INFORMATION

Insurance Co.: _____ Contract # _____ Group # _____

Insurance Address _____

Insured's Name _____ Relationship _____ Self Spouse Dependent

Insured's Employer _____ Insured's Social Security # _____

Date of Birth _____ Sex _____ M _____ F _____ F

I hereby assign, transfer, and set over to regional Cardiology Associates, PLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature _____ Date _____